Complete Summary

GUIDELINE TITLE

Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London (UK): British Psychological Society, Royal College of Psychiatrists; 2006. 350 p. (National clinical practice guideline; no. 31). [716 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- June 17, 2008 – Antipsychotics (conventional and atypical]): The U.S. Food and Drug Administration (FDA) notified healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis. The prescribing information for all antipsychotic drugs will now include information about the increased risk of death in the BOXED WARNING and WARNING sections.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Obsessive-compulsive disorder and body dysmorphic disorder

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Hospitals
Nurses
Patients
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

To make recommendations for the identification, treatment and management of obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD). Specifically, it aims to:

- Evaluate the role of specific psychological interventions in the treatment and management of OCD and BDD
- Evaluate the physical management and role of specific pharmacological agents in the treatment of OCD and BDD
- Evaluate the role of other biological interventions in the management of OCD and BDD
- Integrate the above to provide best practice advice on the care of individuals with a diagnosis of OCD or BDD throughout the course of the disorder

- Promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales

TARGET POPULATION

People with a diagnosis of obsessive-compulsive disorder (OCD) or body dysmorphic disorder (BDD) aged 8 years and over, and their families/carers

INTERVENTIONS AND PRACTICES CONSIDERED

Screening/Assessment

1. Screening of individuals at high risk of obsessive-compulsive disorder (OCD) or body dysmorphic disorder (BDD)
2. Assessment of comorbid conditions and risk of self-harm or suicide
3. Continuity and co-ordination of care with other healthcare providers and with patient and carers

Psychological Interventions

1. Cognitive behavioural therapy (CBT) (individual or group)
2. Exposure and response prevention (ERP)
3. Guided self-help
4. Close monitoring of patients at a high risk of suicide

Pharmacologic Therapy

1. Selective serotonin reuptake inhibitors (SSRIs)
2. Clomipramine
3. Antipsychotic agents (as an augmentation strategy in children or young people or in adults with poor response to treatment)
4. Combination therapy
5. Monitoring of pharmacological therapy, management of side effects and discontinuation/withdrawal symptoms

Other Measures

1. Hospitalization and in patient treatment
2. Discharge and follow up
3. Support and information for families and carers

MAJOR OUTCOMES CONSIDERED

- Symptom improvement
- Quality of life
- Social function
- Side effects of pharmacologic therapy
- Cost effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Search Process for Questions Concerning Interventions

For questions related to interventions, the initial evidence base was formed from well-conducted randomised controlled trials (RCTs) that addressed at least one of the clinical questions. Although there are a number of difficulties with the use of RCTs in the evaluation of interventions in mental health, the RCT remains the most important method for establishing treatment efficacy. The initial search for RCTs involved searching the standard mental health bibliographic databases (Embase, Medline, PsycInfo, Cochrane Library) for all RCTs potentially relevant to the guideline. If the number of citations generated from this search was large (>5000), question-specific search filters were developed to restrict the search while minimising loss of sensitivity.

After the initial search results were scanned liberally to exclude irrelevant papers, the review team used a purpose built "study information" database to manage both the included and the excluded studies (eligibility criteria were developed after consultation with the Guideline Development Group [GDG]). For questions without good quality evidence (after the initial search), a decision was made by the GDG about whether to: (a) repeat the search using subject-specific databases (for example, CINAHL, AMED, SIGLE or PILOTS); (b) conduct a new search for lower levels of evidence; or (c) adopt a consensus process (see Section 4.4.6.1 of the original guideline document).

Recent high-quality English-language systematic reviews were used primarily as a source of RCTs (see Appendix 7 of the original guideline document for quality criteria). However, where existing datasets were available from appropriate reviews, they were cross-checked for accuracy before use. New RCTs that met the inclusion criteria set by the GDG were incorporated into the existing reviews and fresh analyses performed. The review process is illustrated in Flowchart 1 in the original guideline document.

Additional searches were made of the reference lists of all eligible systematic reviews and RCTs, and the list of evidence submitted by stakeholders. Known experts in the field (see Appendix 4 of the original guideline document), based both on the references identified in early steps and on advice from GDG members, were sent letters requesting systematic reviews or RCTs that were in the process of being published. In addition, the tables of contents of appropriate journals were periodically checked for relevant studies.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must be accompanied by a full trial report or sufficient detail to properly assess the quality of the data. Second, the evidence must be submitted with the understanding that it will be published in the full guideline. For example, the GDG did not accept evidence submitted as commercial in confidence. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their study.

Search Filters

Search filters developed by the review team consisted of a combination of subject heading and free-text phrases. Specific filters were developed for the guideline topic, and where necessary, for each clinical question. In addition, the review team used filters developed for systematic reviews, RCTs and other appropriate research designs (Appendix 6 of the original guideline document).

Study Selection

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each clinical question (see appropriate chapter in the original guideline document). All eligible papers were then critically appraised for methodological quality (see Appendix 8 of the original guideline document). The eligibility of each study was confirmed by at least one member of the group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I: Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Synthesising the Evidence

Where possible, outcome data were extracted directly from all eligible studies, which met the quality criteria, into Review Manager 4.2.7 (Cochrane Collaboration, 2004). Meta-analysis was then used, where appropriate, to synthesise the evidence using Review Manager. If necessary, reanalyses of the data or sensitivity analyses were used to answer clinical questions not addressed in the original studies or reviews. For continuous outcomes, where more than 50% of the total number randomised in a particular study was not accounted for, the data were excluded from the analysis because of the risk of bias. In the case of dichotomous outcomes (except for the outcome of leaving the study early), the effects of high attrition rates were examined with sensitivity analyses.

Methods Used to Develop this Guideline

Evidence tables, generated automatically from the study information database, were used to summarise general information about each study (see Appendix 16 of the original guideline document). Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were also presented in the evidence tables.

Consultation was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer directly into Review Manager and cross-checked with the existing data-set. Two independent reviewers extracted data from new studies, and disagreements were resolved with discussion. Where consensus could not be reached, a third reviewer resolved the disagreement. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution, and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Guideline Development Group (GDG)

The GDG consisted of professionals in psychiatry, clinical psychology, nursing and general practice; academic experts in psychiatry and psychology; and people with obsessive-compulsive disorder (OCD) and a carer. The guideline development process was supported by staff from the National Collaborating Centre for Mental Health (NCCMH), who undertook the clinical and health economics literature searches, reviewed and presented the evidence to the GDG, managed the process, and contributed to the drafting of the guideline.

Guideline Development Group Meetings

Twenty-one GDG meetings were held between June 2003 and May 2005. During each day-long GDG meeting, in a plenary session, clinical questions and clinical evidence were reviewed and assessed, statements developed and recommendations formulated. At each meeting, all GDG members declared any potential conflict of interests, and patient and carer concerns were routinely discussed as part of a standing agenda.

Forming and Grading the Statements and Recommendations

Evidence tables and forest plots formed the basis for developing clinical statements and recommendations.

Intervention Studies

For intervention studies, all evidence was classified according to an accepted hierarchy. Recommendations were then graded A to C based on the level of associated evidence, as a good practice point (GPP).

In order to facilitate consistency in generating and drafting the clinical statements the GDG utilised a statement decision tree (see Flowchart 2 in the original guideline document). The flowchart was designed to assist with, but not replace clinical judgement.

Using the decision tree (Flowchart 2 in the original guideline document), the GDG classified each effect size as clinically important or not (that is, whether or not the treatment is likely to benefit patients), taking into account several factors including statistical significance, the magnitude and precision of the effect, the trial population and the nature of the outcome. The starting point for determining whether or not the magnitude of the effect was likely to be clinically significant was a relative risk (RR) of 0.80 or less and a standardised mean difference (SMD) of –0.50 or less.

Where heterogeneity between studies was judged problematic, either a random effects model was used or sub-analyses were conducted to examine the possibility of moderators.

In cases where an effect was judged clinically important, a further consideration was made about the strength of the evidence by examining the range of estimates defined by the confidence interval (CI). For level-I evidence, where the effect size was judged clinically important for the full range of plausible estimates, the result was characterised as *evidence suggesting a difference favouring x over y on . . .*

(S1 [see Flowchart 2 in the original guideline document]). For non-level-I evidence or in situations where the CI included clinically unimportant effects, the result was characterised as *limited evidence suggesting a difference favouring x over y on . . .* (S2). Where an effect size was judged as not clinically important and the CI did not include any clinically important effects, the result was characterised as *unlikely to be clinically important . . .* (S3).

Alternatively, if the range of estimates defined by the CI included clinically important benefits as well as no effect or harmful effects, the result was characterized as inconclusive (S4).

Once all evidence statements relating to a particular clinical question were finalised and agreed by the GDG, the associated recommendations were produced and graded. Grading allowed the GDG to distinguish between the level of evidence and the strength of the associated recommendation. It is possible that a statement of evidence would cover only one part of an area in which a recommendation was to be made or would cover it in a way that would conflict with other evidence. In order to produce more comprehensive recommendations suitable for people in England and Wales, there were times when the GDG had to extrapolate from the available evidence. This led to a weaker level of recommendation (that is, B, as data were based upon level-I evidence). In addition, it is possible to have methodologically sound (level-I) evidence about an area of practice that is of little direct clinical relevance or has such a small effect that it is of little practical importance. In this case, the evidence would attract a lower strength of recommendation (that is, there would be necessity for extrapolation). It is important to note that the grading of the recommendation is not a reflection of its clinical importance or relevance.

The process also allowed the GDG to moderate recommendations based on factors other than the strength of evidence. Such considerations include the applicability of the evidence to the people in question, economic considerations, values of the development group and society, or the group's awareness of practical issues.

Method Used to Answer a Clinical Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of level-I evidence (or a level that is appropriate to the question), or where the GDG decided (on the basis of previous searches or their knowledge of the literature) that there was unlikely to be such evidence, either an informal or formal consensus process was adopted. This process focused on those questions that the GDG considered a priority.

Informal Consensus

The starting point for this process was that a member of the GDG identified, with help from the systematic reviewer, a narrative review that most directly addressed the clinical question. Where this was not possible, a brief review of the recent literature was initiated.

This existing narrative review or new review was used as a basis for beginning an iterative process to identify lower levels of evidence relevant to the clinical

question and to lead to written statements for the guideline. The process involved a number of steps:

- A description of what is known about the issues concerning the clinical question was written by one of the GDG members.
- Evidence from the existing review or new review was then presented in narrative form to the GDG and further comments were sought about the evidence and its perceived relevance to the clinical question.
- Based on this feedback, additional information was sought and added to the information collected. This may include studies that did not directly address the clinical question but were thought to contain relevant data.
- If, during the course of preparing the report, a significant body of primary-level studies (of appropriate design to answer the question) were identified, a full systematic review was done.
- Following this, on occasions and as deemed appropriate by the GDG, the report was then sent to appointed experts outside of the group for peer review and comment. The information from this process was then fed back to the GDG for further discussion of the statements.
- Recommendations were then developed and could also be sent for further external peer review.
- After this final stage of comment, the recommendations were again reviewed and agreed upon by the GDG.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of the Recommendations

Grade A - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation

Grade B - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence

Grade C - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level-I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

Good Practice Point (GPP) - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)

COST ANALYSIS

The aim of the health economics review was to contribute to the guideline development process. Data on the economic burden of obsessive-compulsive disorder (OCD) and evidence of cost effectiveness of the different treatment options for OCD were collected and assessed to help the decision-making process. See Chapter 9 of the original guideline document for the detailed health economic review strategies.

The National Cost Impact Report gives a national picture of current practice and the potential changes arising from implementation of the National Institute for Clinical Excellence (NICE) guideline on OCD. It was produced by developing a model based on expert opinion and on the detailed data that is available and has been validated by other experts on OCD.

The guideline developers considered this assessment to be reasonable, given the limited detailed data regarding diagnosis and treatment paths and the time available. However, the costs presented are estimates and should not be taken as the full cost of implementing the guideline.

Details of the cost analysis are available in the companion document "National cost-impact report" (see "Availability of Companion Documents" field).

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was validated through two consultations.

1. The first draft of the guideline (The full guideline, National Institute for Clinical Excellence (NICE) guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the Full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (**I-IV**) and grading of recommendations (**A-C** and **GPP**) are defined at the end of the Major Recommendations field.

Key Priorities for Implementation

All People with Obsessive-Compulsive Disorder (OCD) or Body Dysmorphic Disorder (BDD)

- Each Primary Care Trust (PCT), mental healthcare trust, and children's trust that provides mental health services should have access to a specialist obsessive-compulsive disorder/body dysmorphic disorder multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment

and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.

- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

Adults with OCD or BDD

- In the initial treatment of adults with OCD, low intensity psychological treatments (including exposure and response prevention [ERP]) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:
    - Brief individual cognitive behavioural therapy (CBT) (including ERP) using structured self-help materials
    - Brief individual CBT (including ERP) by telephone
    - Group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).
- Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin reuptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

Children and Young People with OCD or BDD

- Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.
- Following multidisciplinary review, for a child (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered.

Careful monitoring should be undertaken, particularly at the beginning of treatment.

- Following multidisciplinary review, for a young person (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

Good Practice Points Relevant to The Care of All People With OCD or BDD and Their Families or Carers

Understanding

GPP - People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends, family or carers. Healthcare professionals should help patients, and their families or carers where appropriate, to understand the involuntary nature of the symptoms by providing accurate information in an appropriate format on current understanding of the disorders from psychological and/or biological perspectives.

GPP - When assessing people with OCD or BDD, healthcare professionals should sensitively explore the hidden distress and disability commonly associated with the disorders, providing explanation and information wherever necessary. In particular, people with OCD who are distressed by their obsessive thoughts should be informed that such thoughts are occasionally experienced by almost everybody and, when frequent and distressing, are a typical feature of OCD.

Continuity of Care

GPP - OCD and BDD are frequently recurring or chronic conditions that often affect some of the most intimate aspects of a person's life. Healthcare professionals should therefore ensure continuity of care and minimise the need for multiple assessments by different healthcare professionals.

GPP - Because OCD and BDD may occur across a person's lifespan, particular care should be given to the provision of appropriate care at all ages and a seamless transition between services aimed at specific ages, such as the transition from services for young people to services for adults.

GPP - Careful consideration should be given to the effective integration and coordination of care of people with OCD and BDD across both primary and secondary care. There should be clear, written agreement among individual healthcare professionals about the responsibility for monitoring and treating people with OCD and BDD. A written copy of this agreement should be given to the patient. This should be in collaboration with the patient, and where appropriate.

- The Care Programme Approach (CPA) should be used
- The patient's family or carers should be involved
- Healthcare professionals should liaise with other professionals involved in providing care and support to the patient

Information and Support

GPP - Treatment and care should take into account the individual needs and preferences of people with OCD or BDD. Patients should have the opportunity to make informed decisions about their care and treatment. Where patients do not have the capacity to make decisions, or children or young people are not old enough to do so, healthcare professionals should follow the Department of Health guidelines.

GPP - Good communication between healthcare professionals and people with OCD or BDD is essential. Provision of information, treatment and care should be tailored to the needs of the individual, culturally appropriate, and provided in a form that is accessible to people who have additional needs, such as learning difficulties, physical or sensory disabilities, or limited competence in speaking or reading English.

GPP - Healthcare professionals should consider informing people with OCD or BDD and their family or carers about local self-help and support groups, and encourage them to participate in such groups where appropriate.

Religion and Culture

GPP - Obsessive-compulsive symptoms may sometimes involve a person's religion, such as religious obsessions and scrupulosity, or cultural practices. When the boundary between religious or cultural practice and obsessive-compulsive symptoms is unclear, healthcare professionals should, with the patient's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process.

Families and Carers

GPP - Because OCD and BDD often have an impact on families and carers, healthcare professionals should promote a collaborative approach with people with OCD or BDD and their family or carers, wherever this is appropriate and possible.

GPP - In the treatment and care of people with OCD or BDD, family members or carers should be provided with good information (both verbal and written) about the disorder, its likely causes, its course and its treatment.

GPP - Assessment and treatment plans for people with OCD or BDD should, where appropriate, involve relevant family members or carers. In some cases, particularly with children and young people, when the symptoms of OCD or BDD interfere with academic or workplace performance, it may be appropriate to liaise with professionals from these organisations. Assessment should include the impact of rituals and compulsions on others (in particular on dependent children)

and the degree to which carers are involved in supporting or carrying out behaviours related to the disorder.

GPP - If dependent children are considered to be at risk of emotional, social, or mental health problems as a result of the behaviour of a parent with OCD or BDD and/or the child's involvement in related activity, independent assessment of the child should be requested. If this is carried out, the parent should be kept informed at every stage of the assessment.

GPP - In the treatment of people with OCD or BDD, especially when the disorder is moderate to severe or chronic, an assessment of their carer's social, occupational, and mental health needs should be offered.

Stepped Care for Adults, Young People and Children with OCD Or BDD

The stepped-care model draws attention to the different needs of people with OCD and BDD, depending on the characteristics of their disorder, their personal and social circumstances, their age, and the responses that are required from services. It provides a framework in which to organise the provision of services in order to identify and access the most effective interventions (see Figure 4 in the original guideline document).

Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person's needs. It assumes that the course of the disorder is monitored and referral to the appropriate level of care is made depending on the person's difficulties. Each step introduces additional interventions; the higher steps normally assume interventions in the previous step have been offered and/or attempted, but there are situations where an individual may be referred to any appropriate level. The guidance follows the steps in the figure.

At all stages of assessment and treatment, families or carers should be involved as appropriate. This is particularly important in the treatment of children and young people with OCD or BDD where it may also be helpful to involve others in their network, for example teachers, school health advisors, educational psychologists, and educational social workers.

Step 1: Awareness and Recognition

Although the more common forms of OCD are likely to be recognised when people report symptoms, less common forms of OCD and many cases of BDD may remain unrecognised, sometimes for many years. Relatively few mental health professionals or general practitioners (GPs) have expertise in the recognition, assessment, diagnosis and treatment of the less common forms of OCD and BDD.

GPP - Each PCT, mental healthcare trust, and children's trust that provides mental health services should have access to a specialist OCD/BDD multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when

appropriate, conduct expert assessment and specialist cognitive behavioural and pharmacological treatment.

GPP - Specialist mental health professionals in OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding of the disorders and improve access to high-quality information about them. Such information should also be made available to primary and secondary healthcare professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD.

Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families or carers to provide training for all mental health professionals, cosmetic surgeons, and dermatology professionals.

Step 2: Recognition and Assessment

OCD

C - For people known to be at higher risk of OCD (such as individuals with symptoms of depression, anxiety, alcohol or substance misuse, BDD, or an eating disorder), or for people attending dermatology clinics, healthcare professionals should routinely consider and explore the possibility of comorbid OCD by asking direct questions about possible symptoms such as the following:

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you would like to get rid of but cannot?
- Do your daily activities take a long time to finish?
- Are you concerned about putting things in a special order or are you very upset by mess?
- Do these problems trouble you?

GPP - In people who have been diagnosed with OCD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Part of the risk assessment should include the impact of their compulsive behaviours on themselves or others. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.

GPP - If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive, or death-related thoughts reported by people with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. These themes are common in people with OCD at any age, and are often misinterpreted as indicating risk.

BDD

GPP - For people known to be at higher risk of BDD (such as individuals with symptoms of depression, social phobia, alcohol or substance misuse, OCD, or an eating disorder), or for people with mild disfigurements or blemishes who are

seeking a cosmetic or dermatological procedure, healthcare professionals should routinely consider and explore the possibility of BDD.

GPP - In the assessment of people at higher risk of BDD, the following five questions should be asked to help identify individuals with BDD:

- Do you worry a lot about the way you look and wish you could think about it less?
- What specific concerns do you have about your appearance?
- On a typical day, how many hours a day is your appearance on your mind? (More than 1 hour a day is considered excessive)
- What effect does it have on your life?
- Does it make it hard to do your work or be with friends?

GPP - People with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific expertise in the management of BDD.

GPP - In people who have been diagnosed with BDD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.

GPP - All children and young people who have been diagnosed with BDD should be assessed for suicidal ideation and a full risk assessment should be carried out before treatment is undertaken. If risks are identified, all professionals involved in primary and secondary care should be informed and appropriate risk management strategies put into place.

GPP - Specialist mental health professionals in BDD should work in partnership with cosmetic surgeons and dermatologists to ensure that an agreed screening system is in place to accurately identify people with BDD and that agreed referral criteria have been established. They should help provide training opportunities for cosmetic surgeons and dermatologists to aid in the recognition of BDD.

Steps 3–5: Treatment Options for People With OCD or BDD

Effective treatments for OCD and BDD should be offered at all levels of the healthcare system. The difference in the treatments at the higher levels will reflect increasing experience and expertise in the implementation of a limited range of therapeutic options. For many people, initial treatment may be best provided in primary care settings. However, people with more impaired functioning, higher levels of comorbidity, or poor response to initial treatment will require care from teams with greater levels of expertise and experience in the management of OCD/BDD.

Irrespective of the level of care, the following recommendations should be taken into account when selecting initial treatments for people with OCD or BDD. The specific recommendations on how to provide these treatments follow in the subsequent sections.

Regulatory authorities have identified that the use of SSRIs to treat depression in children and young people may be associated with the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment. There is no clear evidence of an increased risk of self-harm and suicidal thoughts in young adults aged 18 years or older. But individuals mature at different rates and young adults are at a higher background risk of suicidal behaviour than older adults. Hence, young adults treated with SSRIs should be closely monitored as a precautionary measure. The Committee on Safety of Medicine's Expert Working Group on SSRIs, at a meeting in February 2005, advised that it could not be ruled out that the risk of suicidal behaviour, hostility and other adverse reactions seen in the paediatric depression trials applies to use in children or young people in all indications. Consequently, the recommendations about the use of SSRIs for people of any age with OCD or BDD have taken account of the position of regulatory authorities.

Initial Treatment Options

Adults

The intensity of psychological treatment has been defined as the hours of therapist input per patient. By this definition, most group treatments are defined as low intensity treatment (less than 10 hours of therapist input per patient), although each patient may receive a much greater number of hours of therapy.

C - In the initial treatment of adults with OCD, low intensity psychological treatments (including ERP) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:

- Brief individual CBT (including ERP) using structured self-help materials
- Brief individual CBT (including ERP) by telephone
- Group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format)

C - Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

B - Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

C - Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP).

B - Adults with BDD with mild functional impairment should be offered a course of CBT (including ERP) that addresses key features of BDD in individual or group

formats. The most appropriate format should be jointly decided by the patient and the healthcare professional.

B - Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

C - Adults with BDD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP) that addresses key features of BDD.

Children and Young People

C - For children and young people with OCD with mild functional impairment, guided self-help may be considered in conjunction with support and information for the family or carers.

B - Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) involving the family or carers and adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.

C - All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

B - If psychological treatment is declined by children or young people with OCD or BDD and their families or carers, or they are unable to engage in treatment, an SSRI may be considered with specific arrangements for careful monitoring for adverse events.

C - The co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of parental mental health problems, may be factors if the child or young person's OCD or BDD is not responding to any treatment. Additional or alternative interventions for these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD or BDD.

How to use Psychological Interventions

Training

GPP - All healthcare professionals offering psychological treatments to people of all ages with OCD or BDD should receive appropriate training in the interventions they are offering and receive ongoing clinical supervision in line with the recommendations in *Organising and Delivering Psychological Therapies*, available from the Department of Health Web site.

Adults

B - For adults with obsessive thoughts who do not have overt compulsions, CBT (including exposure to obsessive thoughts and response prevention of mental rituals and neutralising strategies) should be considered.

C - For adults with OCD, cognitive therapy adapted for OCD may be considered as an addition to ERP to enhance long-term symptom reduction.

B - For adults with OCD living with their family or carers, involving a family member or carer as a co-therapist in ERP should be considered where this is appropriate and acceptable to those involved.

C - For adults with OCD with more severe functional impairment who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding, a period of home-based treatment may be considered.

C - For adults with OCD with more severe functional impairment who are housebound and unable to undertake home-based treatment because of the nature of their symptoms (such as contamination concerns or hoarding that prevents therapists' access to the patient's home), a period of CBT by telephone may be considered.

C - For adults with OCD who refuse or cannot engage with treatments that include ERP, individual cognitive therapy specifically adapted for OCD may be considered.

C - When adults with OCD request forms of psychological therapy other than cognitive and/or behavioural therapies as a specific treatment for OCD (such as psychoanalysis, transactional analysis, hypnosis, marital/couple therapy) they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments.

GPP - When family members or carers of people with OCD or BDD have become involved in compulsive behaviours, avoidance or reassurance seeking, treatment plans should help them reduce their involvement in these behaviours in a sensitive and supportive manner.

GPP - Adults with OCD or BDD with significant functional impairment may need access to appropriate support for travel and transport to allow them to attend for their treatment.

GPP - Towards the end of treatment, healthcare professionals should inform adults with OCD or BDD about how the principles learned can be applied to the same or other symptoms if they occur in the future.

Children and Young People

Psychological treatments for children and young people should be collaborative and engage the family or carers. When using psychological treatments for children or young people, healthcare professionals should consider the wider context and other professionals involved with the individual. The recommendations on the use

of psychological interventions for adults may also be considered, where appropriate.

GPP - In the cognitive-behavioural treatment of children and young people with OCD or BDD, particular attention should be given to:

- Developing and maintaining a good therapeutic alliance with the child or young person, as well as their family or carers
- Maintaining optimism in both the child or young person and their family or carers
- Collaboratively identifying initial and subsequent treatment targets with the child or young person
- Actively engaging the family or carers in planning treatment and in the treatment process, especially in ERP where, if appropriate and acceptable, they may be asked to assist the child or young person
- Encouraging the use of ERP if new or different symptoms emerge after successful treatment
- Liaising with other professionals involved in the child or young person's life, including teachers, social workers and other healthcare professionals, especially when compulsive activity interferes with the ordinary functioning of the child or young person
- Offering one or more additional sessions if needed at review appointments after completion of CBT

C - In the psychological treatment of children and young people with OCD or BDD, healthcare professionals should consider including rewards in order to enhance their motivation and reinforce desired behaviour changes.

How to Use Pharmacological Interventions in Adults

Current published evidence suggests that SSRIs are effective in treating adults with OCD or BDD, although evidence for the latter is limited and less certain. However, SSRIs may increase the risk of suicidal thoughts and self-harm in people with depression and in younger people. It is currently unclear whether there is an increased risk for people with OCD or BDD. Regulatory authorities recommend caution in the use of SSRIs until evidence for differential safety has been demonstrated.

Starting the Treatment

Common concerns about taking medication for OCD or BDD should be addressed. Patients should be advised, both verbally and with written material, that:

- **C** - Craving and tolerance do not occur.
- **C** - There is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose.
- **C** - There is a range of potential side effects, including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment.
- **C** - There is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly

GPP - Taking medication should not be seen as a weakness.

Monitoring Risk

GPP - Adults with OCD or BDD started on SSRIs who are not considered to be at increased risk of suicide or self-harm should be monitored closely and seen on an appropriate and regular basis. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the notes.

C - Because of the potential increased risk of suicidal thoughts and self-harm associated with the early stages of SSRI treatment, younger adults (younger than age 30 years) with OCD or BDD, or people with OCD or BDD with comorbid depression, or who are considered to be at an increased risk of suicide, should be carefully and frequently monitored by healthcare professionals. Where appropriate, other carers—as agreed by the patient and the healthcare professional—may also contribute to the monitoring until the risk is no longer considered significant. The arrangements for monitoring should be agreed by the patient and the healthcare professional, and recorded in the notes.

C - For adults with OCD or BDD at a high risk of suicide, a limited quantity of medication should be prescribed.

C - When adults with OCD or BDD, especially those with comorbid depression, are assessed to be at a high risk of suicide, the use of additional support such as more frequent direct contacts with primary care staff or telephone contacts should be considered, particularly during the first weeks of treatment.

C - For adults with OCD or BDD, particularly in the initial stages of SSRI treatment, healthcare professionals should actively seek out signs of akathisia or restlessness, suicidal ideation and increased anxiety and agitation. They should also advise patients to seek help promptly if symptoms are at all distressing.

C - Adults with OCD or BDD should be monitored around the time of dose changes for any new symptoms or worsening of their condition.

Choice of Drug Treatment

<u>Selective Serotonin Reuptake Inhibitors (SSRIs)</u>

A - For adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram.

(Note: Citalopram does not have a UK Marketing Authorisation for use in OCD in adults at the date of publication [November 2005])

B - For adults with BDD (including those with beliefs of delusional intensity), the initial pharmacological treatment should be fluoxetine because there is more evidence for its effectiveness in BDD than there is for other SSRIs.

(Note: Fluoxetine does not have a UK Marketing Authorisation for use in BDD at the date of publication [November 2005])

C - In the event that an adult with OCD or BDD develops marked and/or prolonged akathisia, restlessness or agitation while taking an SSRI, the use of the drug should be reviewed. If the patient prefers, the drug should be changed to a different SSRI.

GPP - Healthcare professionals should be aware of the increased risk of drug interactions when prescribing an SSRI to adults with OCD or BDD who are taking other medications.

GPP - For adults with OCD or BDD, if there has been no response to a full course of treatment with an SSRI, healthcare professionals should check that the patient has taken the drug regularly and in the prescribed dose and that there is no interference from alcohol or substance use.

C - For adults with OCD or BDD, if there has not been an adequate response to a standard dose of an SSRI, and there are no significant side effects after 4–6 weeks, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics.

GPP - For adults with OCD or BDD, the rate at which the dose of an SSRI should be increased should take into account therapeutic response, adverse effects, and patient preference. Patients should be warned about, and monitored for, the emergence of side effects during dose increases.

C - If treatment for OCD or BDD with an SSRI is effective, it should be continued for at least 12 months to prevent relapse and allow for further improvements.

GPP - When an adult with OCD or BDD has taken an SSRI for 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), healthcare professionals should review with the patient the need for continued treatment. This review should consider the severity and duration of the initial illness, the number of previous episodes, the presence of residual symptoms, and concurrent psychosocial difficulties.

GPP - If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months after remission (symptoms are not clinically significant and the person is fully functioning for at least 12 weeks), the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes.

C - For adults with OCD or BDD, to minimise discontinuation/withdrawal symptoms when reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the person's need. The rate of reduction should take into account the starting dose, the drug half-life, and particular profiles of adverse effects.

C - Healthcare professionals should encourage adults with OCD or BDD who are discontinuing SSRI treatment to seek advice if they experience significant discontinuation/withdrawal symptoms.

<u>Other Drugs</u>

C - The following drugs should not normally be used to treat OCD or BDD without comorbidity:

- Tricyclic antidepressants other than clomipramine
- Tricyclic-related antidepressants
- Serotonin and noradrenaline reuptake inhibitors (SNRIs), including venlafaxine
- Monoamine-oxidase inhibitors (MAOIs)
- Anxiolytics (except cautiously for short periods to counter the early activation of SSRIs)

C - Antipsychotics as a monotherapy should not normally be used for treating OCD.

C - Antipsychotics as a monotherapy should not normally be used for treating BDD (including beliefs of delusional intensity).

Poor Response to Initial Treatment for Adults

If initial treatment does not result in a clinically significant improvement in both symptoms and functioning, other treatment options should be considered. When additional treatment options also fail to produce an adequate response, multidisciplinary teams with specific expertise in OCD/BDD should become involved. Their role should include supporting and collaborating with those professionals already involved in an individual's care.

GPP - For adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), a multidisciplinary review should be carried out.

C - Following multidisciplinary review, for adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), combined treatment with CBT (including ERP) and an SSRI should be offered.

C - For adults with OCD or BDD, if there has not been an adequate response after 12 weeks of combined treatment with CBT (including ERP) and an SSRI, or there has been no response to an SSRI alone, or the patient has not engaged with CBT, a different SSRI or clomipramine should be offered.

C - Clomipramine should be considered in the treatment of adults with OCD or BDD after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine or has had a previous good response to it.

GPP - For adults with OCD or BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning.

GPP - The assessment of adults with OCD or BDD referred to multidisciplinary teams with specific expertise in OCD/BDD should include a comprehensive assessment of their symptom profile, previous pharmacological and psychological treatment history, adherence to prescribed medication, history of side effects, comorbid conditions such as depression, suicide risk, psychosocial stressors, relationship with family and/or carers, and personality factors.

C - Following multidisciplinary review, for adults with OCD if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- Additional CBT (including ERP) or cognitive therapy
- Adding an antipsychotic to an SSRI or clomipramine
- Combining clomipramine and citalopram

Following multidisciplinary review, for adults with BDD, if there has been no response to a full trial of at least one SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the following treatment options should also be considered (note, there is no evidence of the optimal sequence of the options listed below):

- **GPP** - Additional CBT or cognitive therapy by a different multidisciplinary team with expertise in BDD
- **C** - Adding buspirone to an SSRI

(Note: Buspirone does not have a UK Marketing Authorisation for use in BDD at the date of publication [November 2005]).

GPP - For adults with BDD, if there has been no response to treatment, or the patient is not receiving appropriate treatment, more intensive monitoring is needed because the risk of suicide is high in people with BDD.

GPP - Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care.

How to use Clomipramine for Adults

GPP - For adults with OCD or BDD who are at a significant risk of suicide, healthcare professionals should only prescribe small amounts of clomipramine at a time because of its toxicity in overdose (refer to the Summary of Product Characteristics for details about appropriate dosage). The patient should be monitored regularly until the risk of suicide has subsided.

C - An electrocardiogram (ECG) should be carried out and a blood pressure measurement taken before prescribing clomipramine for adults with OCD or BDD at significant risk of cardiovascular disease.

C - For adults with OCD or BDD, if there has not been an adequate response to the standard dose of clomipramine, and there are no significant side effects, a

gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics.

B - For adults with OCD or BDD, treatment with clomipramine should be continued for at least 12 months if it appears to be effective and because there may be further improvement.

C - For adults with OCD or BDD, when discontinuing clomipramine, doses should be reduced gradually in order to minimise potential discontinuation/ withdrawal symptoms.

Poor Response to Initial Treatment in Children and Young People

Current published evidence suggests that SSRIs are effective in treating children and young people with OCD. The only SSRIs licensed for use in children and young people with OCD are fluvoxamine and sertraline. When used as a treatment for depression, SSRIs can cause significant adverse reactions, including increased suicidal thoughts and risk of self-harm, but it is not known whether this same risk occurs with their use in OCD. SSRIs may be safer in depression when combined with psychological treatments (see the NICE guideline Depression in children and young people, available from www.nice.org.uk/CG028). Given that the UK regulatory authority has advised that similar adverse reactions cannot be ruled out in OCD, appropriate caution should be observed, especially in the presence of comorbid depression.

GPP - For a child or young person with OCD or BDD, if there has not been an adequate response within 12 weeks to a full trial of CBT (including ERP) involving the family or carers, a multidisciplinary review should be carried out.

C - Following multidisciplinary review, for a *child* (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

B Following multidisciplinary review, for a *young person* (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

C - For a child or a young person with OCD or BDD, if treatment with an SSRI in combination with CBT (including ERP) involving the family or carers is unsuccessful or is not tolerated because of side effects, the use of another SSRI or clomipramine with careful monitoring may be considered, especially if the child or young person has had a positive response to these alternatives in the past. This should also be in combination with CBT (including ERP).

(Note: Clomipramine does not have a UK Marketing Authorisation for use in OCD and BDD in children and young people at the date of publication [November 2005])

How to Use Pharmacological Treatments in Children and Young People

In adults with OCD treated by medication, there is some clinical trial evidence regarding the onset of therapeutic response, the dose needed, the rate of increase of dose, the duration of treatment, and the likelihood of relapse on discontinuation. Trials of these aspects have not been done in children and/or young people, but the following good practice for prescribing SSRIs or clomipramine is based on adult trials and clinical experience.

How to Use SSRIs in Children and Young People

GPP - An SSRI should only be prescribed to children and young people with OCD or BDD following assessment and diagnosis by a child and adolescent psychiatrist who should also be involved in decisions about dose changes and discontinuation.

C - When an SSRI is prescribed to children and young people with OCD or BDD, it should be in combination with concurrent CBT (including ERP). If children and young people are unable to engage with concurrent CBT, specific arrangements should be made for careful monitoring of adverse events and these arrangements should be recorded in the notes.

GPP - Children and young people with OCD or BDD starting treatment with SSRIs should be carefully and frequently monitored and seen on an appropriate and regular basis. This should be agreed by the patient, his or her family or carers and the healthcare professional, and recorded in the notes.

A - A licensed medication (sertraline or fluvoxamine]) should be used when an SSRI is prescribed to children and young people with OCD, except in patients with significant comorbid depression when fluoxetine should be used, because of current regulatory requirements.

(Note: Sertraline has a UK Marketing Authorisation for use in OCD in children over 6 years at the date of publication [November 2005].Fluvoxamine has a UK Marketing Authorisation for use in OCD in children over 8 years at the date of publication [November 2005]. Fluoxetine does not have a UK Marketing Authorisation for use in OCD in children and young people at the date of publication [November 2005].)

C - Fluoxetine should be used when an SSRI is prescribed to children and young people with BDD.

(Fluoxetine does not have a UK Marketing Authorisation for use in BDD at the date of publication [November 2005])

GPP - For children and young people with OCD or BDD who also have significant depression, the NICE recommendations for the treatment of childhood depression (Depression in children: identification and management of depression in children

and young people in primary care and specialist services. NICE Clinical Guideline No. 28, available from www.nice.org.uk/CG028) should be followed and there should be specific monitoring for suicidal thoughts or behaviours.

GPP - Children and young people with OCD or BDD starting treatment with SSRIs should be informed about the rationale for the drug treatment, the delay in onset of therapeutic response (up to 12 weeks), the time course of treatment, the possible side effects, and the need to take the medication as prescribed. Discussion of these issues should be supplemented by written information appropriate to the needs of the child or young person and their family or carers.

C - The starting dose of medication for children and young people with OCD or BDD should be low, especially in younger children. A half or quarter of the normal starting dose may be considered for the first week.

C - If a lower dose of medication for children and young people with OCD or BDD is ineffective, the dose should be increased until a therapeutic response is obtained, with careful and close monitoring for adverse events. The rate of increase should be gradual and should take into account the delay in therapeutic response (up to 12 weeks) and the age of the patient. Maximum recommended doses for children and young people should not be exceeded.

GPP - Children and young people prescribed an SSRI, and their families or carers, should be informed by the prescribing doctor about the possible appearance of suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment. They should be advised that if there is any sign of new symptoms of these kinds, they should make urgent contact with their medical practitioner.

C - Where children or young people with OCD or BDD respond to treatment with an SSRI, medication should be continued for at least 6 months postremission (i.e., symptoms are not clinically significant and the child or young person is fully functioning for at least 12 weeks).

How to use Clomipramine in Children and Young People

C - Children and young people with OCD or BDD and their families or carers should be advised about the possible side effects of clomipramine, including toxicity in overdose.

C - Before starting treatment with clomipramine in children and young people with OCD or BDD, an ECG should be carried out to exclude cardiac conduction abnormalities.

C - For a child or young person with OCD or BDD, if there has not been an adequate response to the standard dose of clomipramine, and there are no significant side effects, a gradual increase in dose may be cautiously considered.

B - Treatment of a child or young person with OCD or BDD with clomipramine should be continued for at least 6 months if the treatment appears to be effective, because there may be further improvement in symptoms.

Stopping or Reducing SSRIs and Clomipramine in Children and Young People

C - In children and young people with OCD or BDD, an attempt should be made to withdraw medication if remission has been achieved (i.e., symptoms are no longer clinically significant and the child or young person is fully functioning) and maintained for at least 6 months, and if that is their wish. Patients and their family or carers should be warned that relapse and/or discontinuation/withdrawal symptoms may occur. They should be advised to contact their medical practitioner should symptoms of discontinuation/ withdrawal arise.

C - For children and young people with OCD or BDD, to minimise discontinuation/withdrawal symptoms on reducing or stopping antidepressants, particularly SSRIs, the dose should be tapered gradually over several weeks according to the individual's need. The rate of reduction should take into account the starting dose, the drug half-life, and particular profiles of adverse effects.

C - Children and young people with OCD or BDD should continue with psychological treatment throughout the period of drug discontinuation because this may reduce the risk of relapse.

Other Drugs

C - Tricyclic antidepressants other than clomipramine should not be used to treat OCD or BDD in children and young people.

C - Other antidepressants (MAOIs, SNRIs) should not be used to treat OCD or BDD in children and young people.

C - Antipsychotics should not be used alone in the routine treatment of OCD or BDD in children or young people, but may be considered as an augmentation strategy.

Step 6: Intensive Treatment And Inpatient Services For People With OCD Or BDD

C - People with severe, chronic, treatment-refractory OCD or BDD should have continuing access to specialist treatment services staffed by multidisciplinary teams of healthcare professionals with expertise in the management of the disorders.

GPP - Inpatient services, with specific expertise in OCD and BDD, are appropriate for a small proportion of people with these disorders, and may be considered when:

- There is risk to life.
- There is severe self-neglect.
- There is extreme distress or functional impairment.
- There has been no response to adequate trials of pharmacological/psychological/combined treatments over long periods of time in other settings.

- A person has additional diagnoses, such as severe depression, anorexia nervosa, or schizophrenia, that make outpatient treatment more complex.
- A person has a reversal of normal night/day patterns that make attendance at any daytime therapy impossible.
- The compulsions and avoidance behaviour are so severe or habitual that they cannot undertake normal activities of daily living.

GPP - A small minority of adults with long-standing and disabling obsessive-compulsive symptoms that interfere with daily living and have prevented them from developing a normal level of autonomy may, in addition to treatment, need suitable accommodation in a supportive environment that will enable them to develop life skills for independent living.

GPP - Neurosurgery is not recommended in the treatment of OCD. However, if a patient requests neurosurgery because they have severe OCD that is refractory to other forms of treatment, the following should be taken into consideration:

- Existing published criteria should be used to guide decisions about suitability.
- Multidisciplinary teams with a high degree of expertise in the pharmacological and psychological treatment of OCD should have been recently involved in the patient's care. All pharmacological options should have been considered and every attempt should have been made to engage the individual in CBT (including ERP) and cognitive therapy, including very intensive and/or inpatient treatments.
- Standardised assessment protocols should be used at pre- and postoperation and at medium- and long-term follow-ups in order to audit the interventions. These assessment protocols should include standardized measures of symptoms, quality of life, social and personality function, as well as comprehensive neuropsychological tests.
- Services offering assessment for neurosurgical treatments should have access to independent advice on issues such as adequacy of previous treatment and consent and should be subject to appropriate oversight.
- Post-operative care should be carefully considered, including pharmacological and psychological therapies.
- Services offering assessment for neurosurgical treatments should be committed to sharing and publishing audit information.

GPP - For children and young people with severe OCD or BDD with high levels of distress and/or functional impairment, if there has been no response to adequate treatment in outpatient settings, or there is significant self-neglect or risk of suicide, assessment for intensive inpatient treatment in units where specialist treatment for children or young people with OCD or BDD is available should be offered.

Discharge After Recovery

C - When a person of any age with OCD or BDD is in remission (symptoms are not clinically significant and the person is fully functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental health professional. The exact frequency of contact should be agreed between the professional and the person with OCD or BDD and/or the family and/or carer and recorded in the

notes. At the end of the 12-month period if recovery is maintained the person can be discharged to primary care.

GPP - OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

Definitions:

Hierarchy of Evidence and Recommendations Grading Scheme

<table>
<tr><th>Level</th><th>Type of Evidence</th><th>Grade</th><th>Evidence</th></tr>
<tr><td>I</td><td>Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</td><td>A</td><td>At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation</td></tr>
<tr><td>IIa</td><td>Evidence obtained from at least one well-designed controlled study without randomisation</td><td rowspan="3">B</td><td rowspan="3">Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence</td></tr>
<tr><td>IIB</td><td>Evidence obtained from at least one well-designed quasi-experimental study</td></tr>
<tr><td>III</td><td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies</td></tr>
<tr><td>IV</td><td>Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities</td><td>C</td><td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level-I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.</td></tr>
<tr><td></td><td></td><td>GPP</td><td>Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)</td></tr>
</table>

Adapted from Eccles, M. and Mason, J. (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5, 16; Mann, T. (1996) *Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS*. London: Department of Health.

CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the quick reference guide (see "Availability of Companion Documents" field) for:

Treatment options for people with obsessive-compulsive disorder (OCD) or body dysmorphic disorder (BDD)

- Adults: Overview of treatment pathway for OCD and BDD
- Children and young people: Overview of treatment pathway for OCD and BDD

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of adults, children, and young people with obsessive-compulsive disorder and body dysmorphic disorder

POTENTIAL HARMS

Adverse events associated with pharmacological therapy, including:

- There is a risk of discontinuation/withdrawal symptoms on stopping the drug, missing doses, or reducing the dose **[C]**
- There is a range of potential side effects, including worsening anxiety, suicidal thoughts and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment **[C]**
- There is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly **[C]**

CONTRAINDICATIONS

CONTRAINDICATIONS

- The co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of parental mental health problems, may be factors if the child or young person's obsessive compulsive disorder (OCD) or body dysmorphic disorder (BDD) is not responding to any treatment. Additional or alternative interventions for

these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD or BDD.

- The UK regulatory authority has contraindicated all selective serotonin reuptake inhibitors (SSRIs) in paediatric depressive illness, except fluoxetine. Although the risk associated with the use of SSRIs in children and young people with obsessive-compulsive disorder (OCD) is unclear, appropriate caution should be observed, especially in the presence of comorbid depression.

QUALIFYING STATEMENTS

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This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Resource Implications

Local health communities should review their existing practice for obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) against this guideline. The review should consider the resources required to implement the recommendations set out in this guideline, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of people with OCD and BDD that implementation is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

Information on the cost impact of this guideline in England is available on the National Institute for Clinical Excellence (NICE) Web site and includes a template that local communities can use (http://www.nice.org.uk/).

General

The Department of Health considers implementation of clinical guidelines to be a developmental standard and this will be monitored by the Healthcare Commission. The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from http://www.dh.gov.uk

Audit

Suggested audit criteria are listed in Appendix D of the NICE version of the original guideline document, and can be used to audit practice locally (see "Availability of Companion Documents" field).

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London (UK): British Psychological Society, Royal College of Psychiatrists; 2006. 350 p. (National clinical practice guideline; no. 31). [716 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Group Members: Professor Mark Freeston (*Chair*) Professor of Clinical Psychology, University of Newcastle upon Tyne Newcastle, North Tyneside and Northumberland Mental Health NHS Trust; Dr Tim Kendall (*Facilitator*) Co-Director, The National Collaborating Centre for Mental Health Deputy Director, Royal College of Psychiatrists' Research Unit Consultant Psychiatrist and Medical Director, Community Health Sheffield NHS Trust; Dr Jo Derisley, Chartered Clinical Psychologist, Norfolk & Waveney Mental Health Partnership NHS Trust, Honorary Lecturer, University of East Anglia; Dr Naomi Fineberg, Consultant Psychiatrist, Queen Elizabeth II Hospital, Welwyn Garden City; Ms Tracey Flannaghan, Nurse in Practice, CBT Department, Glenfield Hospital, Leicester; Dr Isobel Heyman, Consultant Child Psychiatrist, Maudsley and Great Ormond Street Hospitals, Children's Department, Maudsley Hospital, London; Mr Richard Jenkins, Systematic Reviewer (2003–2004), The National Collaborating Centre for Mental Health; Mr Christopher Jones, Health Economist, The National Collaborating Centre for Mental Health; Ms Gillian Knight, Representative for People with OCD, London; Dr Karina Lovell, Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, Manchester; Dr Catherine Pettinari, Senior Centre Project Manager, The National Collaborating Centre for Mental Health; Ms Preethi Premkumar, Research Assistant, The National Collaborating Centre for Mental Health; Mr Cliff Snelling, Representative for Carers of People with OCD, Northampton; Dr Clare Taylor, Editor, The National Collaborating Centre for Mental Health; Mr Rowland Urey, Representative for People with OCD, Oldham Open User Forum, Oldham; Dr David Veale, Consultant Psychiatrist in Cognitive Behaviour Therapy, The Priory Hospital North London and the South London and Maudsley Trust, Honorary Senior Lecturer, Institute of Psychiatry, King's College, London; Ms Heather Wilder, Information Scientist, The National Collaborating Centre for Mental Health; Dr Craig Whittington, Senior Systematic Reviewer (2004–2005), The National Collaborating Centre for Mental Health; Dr Steven Williams, General Practitioner, The Garth Surgery, Guisborough

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

At each Guideline Development Group (GDG) meeting, all GDG members declared any potential conflict of interests.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- National Collaborating Centre for Mental Health. Obsessive-compulsive disorder. Obsessive-compulsive disorder: core interventions in the treatment of obsessive- compulsive disorder and body dysmorphic disorder. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Nov. 53 p. (Clinical guideline; no. 31). Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Obsessive-compulsive disorder. Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. Quick reference guide. National Collaborating Centre for Mental Health, 2005 Nov. 24 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- National Institute for Health and Clinical Excellence. Implementing the NICE clinical guideline on obsessive-compulsive disorder. National cost-impact report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Dec. 41 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- National Institute for Health and Clinical Excellence. Obsessive-compulsive disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Nov. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site
- National Institute for Health and Clinical Excellence. Suggested actions for implementing the NICE clinical guideline on obsessive-compulsive disorder. Implementation advice. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Nov. 17 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- National Institute for Health and Clinical Excellence. Obsessive-compulsive disorder. Presenter slides. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Nov. 35 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0919. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria can be found in Appendix D of the NICE version of the original guideline document.

PATIENT RESOURCES

The following is available:

- Treating obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) in adults, children and young people. Understanding NICE guidance – information for people with OCD or BDD, their families and carers, and the public. National Institute for Health and Clinical Excellence (NICE), 2005 Nov. 43 p. Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS), 11 Strand, London, WC2N 5HR. Response Line 0870 1555 455, ref N0920.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on March 26, 2009.

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